FIELD INTERNSHIP PROVIDER INFORMATION FORM

Training Center Name:			
Address:			
EMS Training Prog. Level:	Please select	If Other: _____	
Complete the following information for each ambulance service and/or field provider utilized by your training program for the supervised clinical instruction of your EMS students. Please include a copy of the written agreement between your institution and each agency with this form.			
1. Name of Provider:			
Address:			
Contact Person Name:			
Contact Person Title:			
Contact Person Phone:			
Level of Service:	☐ **ALS**	☐ **BLS**	☐ **Other:** _____
2. Name of Provider:			
Address:			
Contact Person Name:			
Contact Person Title:			
Contact Person Phone:			
Level of Service:	☐ **ALS**	☐ **BLS**	☐ **Other:** _____
3. Name of Provider:			
Address:			
Contact Person Name:			
Contact Person Title:			
Contact Person Phone:			
Level of Service:	☐ **ALS**	☐ **BLS**	☐ **Other:** _____

INSTRUCTIONS:

Please email the completed form to emstraining@rivco.org Once this form has been received, EMS Agency staff will review and communicate back the status.